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IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

THE TRAVELERS INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS

ON APPEALS FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

BRIEF AMICUS CURIAE OF HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF THE APPELLANTS

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INTEREST OF AMICUS CURIAE

Health Insurance Association of America ("HIAA"), a Delaware nonprofit corporation, is an association of 327 private insurance companies, including the Appellants, Metropolitan Life Insurance Company and The Travelers Insurance Company.[1] HIAA's member companies write over 85% of the health insurance policies written by private insurance

[1] HIAA's member companies do not include nonprofit plans such as Blue Cross and Blue Shield.

companies in the United States. At year-end 1982, approximately 112 million Americans were covered by health policies from private insurers.[2] Approximately 85% of these people are covered under group health insurance policies, a substantial majority of which provide health insurance coverage to employee benefit plans that are regulated by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§1001 *et seq.*

The issue in these appeals—whether employee benefit plans regulated by ERISA ("ERISA plans") are subject to state mandated health benefit laws—is one of substantial concern to HIAA and its member companies.

A mandated health benefit law is one that requires a health insurance policyholder to purchase coverage for a particular health care service. Section 47B of Massachusetts General Laws Chapter 175 ("Section 47B") is such a law in that it requires all health insurance policies to include, for Massachusetts residents, certain minimum benefits for expenses arising from the treatment of mental or nervous conditions. With respect to these benefits, the policyholder has no choice. If he wishes to purchase any health insurance at all, he must purchase the coverage mandated by state law.

Mandated health benefit laws dictate what benefits must be included in health insurance policies. When the benefits provided by an ERISA plan are insured by a group health insurance policy, mandated health benefit laws, such as Section 47B, also dictate what benefits must be provided by the plan.

HIAA and its member companies have consistently opposed the enactment of state mandated health benefit laws because of their impact on ERISA plans: these laws restrict design flexibility, inhibit uniformity in benefit packages, increase costs to employers and employees, and create strong disincentives to securing employee benefits through the purchase of insurance.

[2] Health Insurance Association of America, *Source Book of Health Insurance Data, 1982–1983*, Table 1.2 (1984 Update).

Because the Court's decision will determine the enforceability against insured ERISA plans, not only of Section 47B, but of state mandated health benefit laws throughout the country, these appeals are of substantial interest and importance to HIAA and its member companies.

HIAA and its member companies submit that the Supreme Judicial Court for the Commonwealth of Massachusetts was wrong in holding that Section 47B is not preempted by ERISA. Accordingly, HIAA, as the national trade association of the private health insurance industry, files this Brief Amicus Curiae in support of the Appellants. Consent to the filing of this Brief has been obtained from counsel for the Appellants and the Appellee.

SUMMARY OF ARGUMENT

This Court addresses for the first time the question of whether ERISA preempts a state mandated health benefit law. These appeals pose this question in the context of the enforceability of Section 47B against insured ERISA plans.

By dictating benefits that must be provided by an insured ERISA plan, Section 47B indisputably relates to the plan and, therefore, comes within the broad preemption of Section 514(a) of ERISA, 29 U.S.C. §1144(a) (the "ERISA preemption"). Contrary to the decision of the Supreme Judicial Court, Section 47B is not saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. §1144(b)(2)(A) (the "savings clause").

It is evident from the legislative purposes of ERISA, as reflected in its legislative history and elaborated upon in the decisions of this Court in *Alessi v. Raybestos—Manhattan, Inc.*, 451 U.S. 504 (1981) and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890 (1983), that a mandated health benefit law, such as Section 47B, is not a law which regulates insurance within the meaning of the savings clause.

In enacting the savings clause, Congress intended to preserve only those state laws that protect insurance policy-

holders, including ERISA plans, against practices or activities of insurance companies.[3] Such laws regulate marketing and advertising practices, underwriting and rate setting practices, claims payment practices, reserves and investments and other activities which affect the dealings of the insurance company with the policyholder and the reliability of the coverage purchased.

A state mandated health benefit law is not enacted to protect the policyholder from insurance company practices or activities. Rather, it uses insurance as a means of financing, and therefore promoting, particular health care services, to the detriment of the insurance policyholders whose market choices it restricts.

ARGUMENT

HIAA asks the Court to reverse the decision of the Supreme Judicial Court for the Commonwealth of Massachusetts and to hold that Section 47B is not enforceable against insured ERISA plans.

I.

SOUND PUBLIC POLICY DICTATES THAT INSURED ERISA PLANS SHOULD NOT BE SUBJECT TO STATE MANDATED HEALTH BENEFIT LAWS.

Twenty-six states have enacted a total of nearly 70 mandated health benefit laws covering a wide range of health care services.[4] Half of these have enacted laws, similar to Section 47B, requiring health insurance coverage for the

[3] Throughout this Brief, the term "policyholder" includes those being solicited to become policyholders.

[4] In the Appendices to its Brief Amicus Curiae in Support of Jurisdictional Statements, HIAA provided a generalized state-by-state summary of mandated health benefit laws as well as other state laws that attempt to affect the health benefits provided by group policies, including those issued to ERISA plans.

treatment of mental and nervous disorders. One reason for the widespread appearance of such laws has been the dedicated lobbying of mental health care providers, most notably psychiatrists, psychologists, psychotherapists and social workers.

State mandated health benefit laws shift the payment obligation for particular health care services away from the consumer of those services to, in this instance, the ERISA plan.[5] This shift promotes the utilization of the health care services for which benefits are mandated and virtually guarantees that the provider of the services will be paid a reasonable fee for services rendered. It is little wonder that in state after state health care providers have been the principal, and in many instances the only, advocates of mandated health benefit laws.

In the context of ERISA plans, state mandated health benefit laws impose benefits and costs which neither the employer nor the employees may reject or avoid in determining the benefit mix of the plan. As a consequence, these laws severely restrict the freedom of ERISA plans to provide health benefits at a reasonable cost to meet employee needs.

The detrimental effects of mandated health benefit laws on ERISA plans are of three basic types:[6]

State mandated health benefit laws restrict the ability of ERISA plans to tailor health benefit packages to meet the needs of plan beneficiaries and inhibit multistate plans from developing uniform health benefit packages on a national ba-

[5] Although the payment obligation is nominally shifted to an insurance company which either pays the health care provider or reimburses the health care consumer, it is the group policyholder—in this instance the ERISA plan—that actually bears the payment obligation. Premiums for most group coverage are based on prior claims experience. Therefore, what is paid by the insurance company in claims is ultimately paid by the policyholder in future premium payments.

[6] *See generally* Younger, *Mandated Insurance Coverage—The Achilles Heel of State Regulation?*, XXIV A. of Life Ins. Counsel Proc. 765-82 (1978); Buchman, *Extraterritorial Application of State Mandated Group Health Benefits*, 15 Forum 880 (1980).

sis. A cost-effective package of health benefits requires both *flexibility* and *uniformity*—that is, flexibility to design a program that provides the benefits selected by the plan and uniformity that permits each employee, regardless of the state in which he works or lives, to receive the same benefits and to bear the same costs for these benefits as other members of the plan.

State mandated health benefit laws frustrate these design requirements. They force employers and unions to purchase coverages that they neither want nor need. Not only does this unnecessarily increase the cost of insurance for ERISA plans, it also reduces the number of dollars available to these plans for other, more desired benefits.

Moreover, if a mandated health benefit law is enacted to apply to all residents of a state regardless of whether the group policy itself was issued or delivered in the state, uniformity of benefits is impossible.[7] The benefits provided by the group policy must conform not only to the statutory requirements of the state in which the policy was issued and delivered but also to the requirements of the mandated health benefit laws applicable to insureds living in other states. For ERISA plans, this not only introduces administrative complexity, which increases the cost of providing health insurance to the plan, but also results in inequities among plan members inasmuch as some members receive greater benefits than others simply by reason of the state in which they live or work.[8]

[7] Such laws are generically referred to as "extraterritorial". Because group insurance policies are traditionally governed by the laws of the jurisdiction in which they are issued and delivered rather than the laws of the jurisdiction in which each insured lives or works, *Boseman v. Connecticut General Life Insurance Co.*, 301 U.S. 196 (1937), state insurance laws are said to have extraterritorial application when they are intended to affect policies issued and delivered in other jurisdictions. Because Section 47B applies to all group policies, to the extent that they insure Massachusetts residents, regardless of the state of issuance and delivery, Section 47B is extraterritorial.

[8] The problems created by extraterritorial mandated health benefit laws are akin to those recognized by the Court in *Shaw v. Delta Air Lines, Inc.*, 103 S. Ct. at 2904 n.25, regarding the impact of state fair employment laws on multistate ERISA plans.

State mandated health benefit laws are a major contributor to the rapidly escalating cost of health insurance for ERISA plans. Conservative estimates by industry experts place the cost of mandated health benefits at approximately 10% of the policy premium. Other industry experts believe that a more realistic estimate would place the cost of mandated health benefits closer to 20% of the policy premium.

Mandated health benefit laws contribute to increased costs to ERISA plans for several reasons. First, the policy becomes more complicated and, therefore, more costly to administer. These administrative costs are "dead dollars" in that they do not result in increased policy benefits. Second, the policy becomes more expensive because it carries unwanted coverages that the plan was forced by law to purchase. Third, the policy becomes more expensive because the underlying health care costs increase. State mandated health benefit laws are intended to encourage the use of services for which coverage is mandated. Increased use translates directly into increased claims, which in turn results in larger future premiums for group policyholders.

State mandated health benefit laws create disincentives to purchasing insurance. Coverages that are required by state law but unwanted by the policyholder increase the likelihood that the policyholder will choose to buy *no* health insurance at all rather than bear the cost of unwanted coverages. During the last decade, as more states have enacted more mandated health benefit laws at the behest of health care providers, employers and unions have done precisely this. Rather than insuring ERISA plans, an increasing number of employers and unions have elected to fund the benefits themselves. Because ERISA prohibits states from regulating *uninsured* ERISA plans, self-funding effectively enables the plan to avoid state regulation of plan benefits.[9]

[9] Section 514(b)(2)(B) of ERISA, 29 U.S.C. §1144(b)(2)(B), (the "deemer clause") prohibits states from regulating ERISA plans by deeming them to be insurance companies. Courts have consistently interpreted and applied the deemer clause to prohibit state regulation of uninsured plans. *General Split Corp. v. Mitchell*, 523 F. Supp. 427 (E.D. Wisc. 1981); *St. Paul Electrical Workers Welfare Fund v. Markman*, 490 F. Supp. 931 (D. Minn. 1980); *Hewlett-Packard Co. v. Barnes*, 425 F. Supp. 1294 (N.D. Cal. 1977); *aff'd per curiam*, 571 F.2d 502 (9th Cir. 1978).

When an employer or union chooses *not* to purchase health insurance for an ERISA plan, employees and union members suffer because uninsured health benefits are inherently less secure than insured benefits. State insurance laws and regulations protect against insurance company insolvency. No similar protections are available to assure that the assets of an uninsured plan will be sufficient to pay benefits to plan members.

Indeed, one of the major ironies of this case is that if state mandated health benefit laws were to be held to be preserved by the savings clause with respect to *insured* plans, employers and unions would be further encouraged to reject insurance and to provide *uninsured* plans to employees and union members. Because the benefits of an uninsured plan are plainly less secure than those of an insured plan, this result conflicts with the stated purpose of ERISA "to protect . . . the interests of participants in employee benefits plans and their beneficiaries. . . ." Section 2(b) of ERISA, 29 U.S.C. §1001(b).[10]

HIAA submits that, as a matter of sound public policy, employers and unions should not be forced to choose between submitting to costly and restrictive state mandated health benefit laws or leaving the health benefits of their ERISA plans uninsured. HIAA further submits that this sound public policy is reflected in the ERISA preemption and that, as a matter of federal law, ERISA plans are not subject to state laws that dictate health benefits, irrespective of whether these plans are insured or uninsured.

II.

CONGRESS INTENDED ERISA TO PREEMPT STATE LAWS WHICH DICTATE THAT PLANS PROVIDE CERTAIN HEALTH BENEFITS.

The decision in these appeals turns on legislative intent. Both the legislative history of ERISA and this Court's previous decisions construing the scope of the ERISA preemption dictate the conclusion that, in enacting ERISA, Congress intended to preempt state laws, like Section 47B, which would require ERISA plans to provide certain health benefits, irrespective of whether these benefits are insured or uninsured.

[10] For a recent discussion of problems associated with uninsured plans, see Buchman, *Insured and Uninsured METs-Current Problems*, 16 Conn. L. Rev. 453 (1984).

a.

ERISA was enacted to provide a comprehensive federal response to what were perceived to be widespread problems and abuses in the area of employee benefit plans. As this Court observed in *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980) and again in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 510, ERISA is a "comprehensive and reticulated statute", which Congress adopted only after careful study of such plans.

In enacting ERISA, Congress considered the history of prior federal involvement and existing state law (S. Rep. No. 93-127, 93d Cong., 2d Sess. 2-7 (1973)), and concluded that the fragmentary federal and state law that applied to employee benefit plans had not been effective in protecting participants from deprivation of anticipated benefits or in promoting expansion of such plans. Section 2 of ERISA, 29 U.S.C. §1001; H.R. Rep. No. 93-533, 93d Cong., 2d Sess. 1-5 (1973); H.R. Rep. No. 93-807, 93d Cong., 2d Sess. 8-9 (1974); S. Rep. No. 93-127, 93d Cong., 2d Sess. 1-7 (1973). A comprehensive federal approach was required.

As a means of ensuring this comprehensive federal approach to employee benefit plan regulation, Congress enacted the ERISA preemption. The legislative history amply supports the conclusion that, in so doing, Congress intended to occupy the field of employee benefit plan regulation. The conference committee that reported the final version of the bill emphasized that:

> the provisions of title I are to supersede all State laws that relate to any employee benefit plan that is established by an employer engaged in or affecting interstate commerce or by an employee organization that

represents employees engaged in or affecting interstate commerce.

H.R. Rep. No. 93-1280, 93d Cong., 2d Sess. 383 (1974).

In floor debate concerning the conference report, Congressman Dent, the Chairman of the Subcommittee on Labor of the House Labor and Education Committee, elaborated on the purpose of the ERISA preemption by saying that

> [t]he conferees, with the *narrow exceptions* specifically enumerated, applied this principle *in its broadest sense* to foreclose any non-Federal regulation of employee benefit plans. This [preemption] would reach any rule, regulation, practice or decision of any State, subdivision thereof or any agency or instrumentality thereof . . . which would affect any employee benefit plan as described in section 4 (a) and not exempt under section 4 (b).

120 Cong. Rec. 29,197 (1974) (emphasis supplied).

Senator Williams, Chairman of the Senate Committee on Labor and Public Welfare, indicated the reason for the broad preemption:

> It should be stressed that with the *narrow exceptions* specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulation, *thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.*

120 Cong. Rec. 29,933 (1974) (emphasis supplied).

Senator Javits, the senior Republican on the Senate Committee on Labor and Public Welfare, noted during the floor debates on ERISA that

> [a]lthough the desirability of further regulation—at either the State or Federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest *and the interests of uniformity with respect to interstate plans* required—but for certain exceptions—the displacement of State action in the field. . . .

120 Cong. Rec. 29,942 (1974) (emphasis supplied). *See also* Turza & Halloway, *Preemption of State Law under the Employee Retirement Income Security Act of 1974*, 28 Cath. U.L. Rev. 163, 167 (1979); Hutchinson & Ifshin, *Federal Preemption of State Law under the Employee Retirement Income Security Act of 1974*, 46 U. Chi. L. Rev. 23, 38-43 (1978).

This legislative history dictates the conclusion that Congress intended the ERISA preemption to be broadly applied and the savings clause to be narrowly construed.

b.

On two occasions this Court has addressed the scope of the ERISA preemption and has held it to be applied broadly. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). Both cases strongly support the proposition that a state law, like Section 47B, which would require ERISA plans to provide certain health benefits, is inconsistent with the broad legislative purposes of the ERISA preemption.

In *Alessi* the Court unanimously held that the New Jersey Workers' Compensation Act was preempted by ERISA insofar as the state law prohibited workers' compensation payments from being set off against pension benefits payable by an ERISA plan. While acknowledging that workers' compensation awards were "obviously . . . subject to the State's police power", 451 U.S. at 524, the Court concluded that even indirect intrusion upon the provisions of an ERISA plan could not escape the ERISA preemption.

> It is of no moment that New Jersey intrudes *indirectly*, through a workers' compensation law, rather than directly, through a statute called 'pension regulation'. ERISA makes clear that even *indirect* state action bearing on private pensions may encroach upon the area of exclusive federal concern.

451 U.S. at 525 (emphasis supplied).

The same, of course, may be said for state mandated health benefit laws: while these laws are within a state's police power, the state is prohibited by the ERISA preemption from dictating the benefits an ERISA plan, either directly, or, as in the case of Section 47B, indirectly through the plan's group health insurance policy.

The Court in *Alessi* also observed that Congress had reserved decisions on pension calculation techniques "to the discretion of pension plan designers". 451 U.S. at 525. Similarly, the selection of health benefits to be provided by an ERISA plan appropriately is left to the discretion of plan designers. Because state laws, like Section 47B, limit this discretion, they conflict with the legislative purposes of ERISA.[11]

This discretion and design flexibility are all the more important where the benefit package emerges from collective bargaining. As the Court stated in *Alessi*: "the additional federal interest in precluding state interference with labor-management negotiations calls for preemption of state efforts to regulate pension terms. . . . As a subject of collective bargaining, pension terms themselves become expressions of federal law, requiring preemption of intrusive state law." 451 U.S. at 525 (citations omitted). By analogy, to the extent the benefit mix in an ERISA plan is subject to collective bargaining, the state's attempt to interfere with this process by enacting mandated health benefit laws contravenes federal labor policy.[12]

[11] In *Alessi* specific legislative history supported the conclusion that pension calculation techniques were to be left to the discretion of pension plan designers. 451 U.S. at 514-16. The reasoning with respect to benefit selection is identical. Plan designers should be permitted to weigh costs and benefits and determine a benefit mix that is consistent with plan objectives.

[12] The Brief of the Appellant The Travelers Insurance Company, to which HIAA subscribes, addresses this aspect of these appeals in detail.

In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890 (1983), the Court unanimously held that the New York Human Rights Law was preempted by ERISA and that the New York Disability Benefits Law was preempted insofar as it applied to an ERISA plan not maintained solely for the purpose of complying with that state law.

The New York Human Rights Law, as construed by the New York Court of Appeals, prohibits an ERISA plan from treating pregnancy differently from other nonoccupational disabilities, and the New York Disability Benefits Law requires employers to pay certain benefits to employees unable to work because of nonoccupational injuries or illness, including pregnancy-related disabilities.

The Court in *Shaw* had no difficulty concluding that these state laws were within the broad reach of the ERISA preemption:

> The breadth of §514(a)'s pre-emptive reach is apparent from that section's language. A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such plan. Employing this definition, the Human Rights Law, *which prohibits employers from structuring their employee benefit plans* in a manner that discriminates on the basis of pregnancy, and the Disability Benefits Law, *which requires employers to pay employees specific benefits*, clearly 'relate to' benefit plans.

103 S. Ct. at 2899-2900 (emphasis supplied; footnotes omitted).

The Court's decision that the state laws were preempted by ERISA was based in part on the conclusion that Congress intended to minimize the burden on *multistate* employers to administer plans differently in each state in which they have employees. 103 S. Ct. at 2904-5. The Court elaborated on this point with respect to the New York Human Rights Law:

> An employer with employees in many States might find that the most efficient way to provide benefits to

those employees is through a single employee benefit plan. *Obligating the employer to satisfy the varied and perhaps conflicting requirements of particular state fair employment laws, as well as the requirements of Title VII, would make administration of a uniform nationwide plan more difficult.* The employer might choose to offer a number of plans, each tailored to the laws of a particular State; the inefficiency of such a system presumably would be paid by lowering benefit levels. Alternatively, assuming that the state laws were not in conflict, the employer could comply with the laws of all States in a uniform plan. To offset the additional expenses, the employer presumably would reduce wages or eliminate those benefits not required by any State. Another means by which the employer could retain its uniform nationwide plan would be by eliminating classes of benefits that are subject to state requirements with which the employer is unwilling to comply. *ERISA's comprehensive pre-emption of state law was meant to minimize this sort of interference with the administration of employee benefit plans.*

103 S. Ct. at 2904 n. 25 (emphasis supplied). This description of the obvious impact of state law on multistate plans argues convincingly for the preemption not only of state fair employment laws, but of state laws, like Section 47B, which dictate that insured plans provide different health benefits to plan members residing or working in different states.

III.

A MANDATED HEALTH BENEFIT LAW DOES NOT PROTECT POLICYHOLDERS FROM INSURANCE COMPANY PRACTICES, AND, THEREFORE, IS NOT A LAW WHICH REGULATES INSURANCE WITHIN THE MEANING OF THE SAVINGS CLAUSE.

The legislative history of ERISA and this Court's decisions in *Alessi* and *Shaw* make a compelling case that Con-

gress intended ERISA to preempt state laws that interfere with the uniform administration of ERISA plans and with the flexibility and discretion of plan designers.

Indisputably, state mandated health benefit laws, like Section 47B, have this effect. The Supreme Judicial Court nevertheless held that, because Section 47B operates through a plan's group health insurance policy rather than on the plan directly, it is a law which regulates insurance and, therefore, is within the scope of the savings clause.

A number of appellate courts have addressed the relationship of a state mandated health benefit law and ERISA. *Attorney General v. The Travelers Insurance Co.*, 391 Mass. 730, 463 N.E.2d 548 (1984), *juris. noted* 105 S. Ct. 320 (1984); *Insurance Commissioner v. Metropolitan Life Insurance Co.*, 296 Md. 334, 463 A.2d 793 (1983); *Wadsworth v. Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied* 435 U.S. 980 (1978). None of these cases has engaged in a substantive analysis of whether a state mandated health benefit law is one that regulates insurance within the meaning of the savings clause.[13]

The question posed by these appeals is far more complex than a reading of the opinions cited above would lead one to believe. These courts have largely assumed that, because a mandated health benefit law is found in the state insurance

[13] Not coincidentally, the one appellate court that did engage in such an analysis concluded that the state mandated health benefit law in question did *not* regulate insurance within the meaning of the savings clause, and held the state law unenforceable against an insured ERISA plan. *Metropolitan Life Insurance Co. v. Insurance Commissioner*, 51 Md. App. 122, 441 A.2d 1098 (1982), *rev'd* 296 Md. 334, 463 A.2d 793 (1983). In reversing this decision the Maryland Court of Appeals ignored completely the reasoning of the intermediate court. See *Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 572 F. Supp. 943, 950-52 (E.D. Mich. 1983), in which the court similarly concluded that state mandated health benefit laws are not laws which regulate insurance within the meaning of the savings clause.

code, it is a law which regulates insurance.[14] The issue posed by these appeals is not whether a state mandated health benefit law *affects* insurance policies but whether, when its substantive effect is examined, it is a law which *regulates* insurance within the meaning of the savings clause.

HIAA submits that Section 47B and other state mandated health benefit laws are not laws which regulate insurance within the meaning of the savings clause. Congress carved out this exception to the ERISA preemption in order to give ERISA plans the benefit of those state laws that have traditionally afforded insurance policyholders protection against insurance company activities or practices.[15] Because Section 47B and other state mandated health benefit laws are not laws that protect the policyholder from injury that might be suffered as a result of insurance company activities or practices but rather are laws that use insurance to finance and, hence, to promote particular health care services, they are not laws of the type Congress intended to be saved from preemption.

a.

The legislative history of ERISA does not reveal Congress' view on what constitutes a "law . . . which regulates insurance. . . ." Therefore, it is necessary to infer legislative

[14] In contrast to this approach, see *Stone & Webster Engineering Corp. v. Ilsley*, 518 F. Supp. 1297, 1299 n.2 (D. Conn. 1981), *aff'd* 690 F.2d 323 (2d Cir. 1982), *aff'd sub nom. Arcudi v. Stone & Webster Engineering Corp.*, 103 S. Ct. 3564 (1983) (a state law requiring employer contributions to an employee union welfare fund providing life and health insurance benefits is not a law regulating insurance but rather a law aimed at *employers* and, as such, is preempted by ERISA). See also *Securities & Exchange Commission v. National Securities*, 393 U.S. 453, 460 (1969), in which the Court observed that a particular state law "is not insurance regulation, but securities regulation. It is true that the state statute applies only to insurance companies. But mere matters of form need not detain us."

[15] As Chief Judge Feikens concluded in *Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 572 F. Supp. at 951: "The saving clause may preserve the state's power to regulate certain types of institutions important to the fabric of state life, and generally excluded from federal regulation, but I would confine the term 'regulates insurance' so as to exclude laws which do not so much monitor the insurance industry as its customers from the clause's protection."

intent from the structure and purpose of the ERISA preemption, and from the common understanding of state insurance regulation.

ERISA'S declared purpose is "to protect . . . the interest of participants in employee benefit plans and their beneficiaries. . . ." Section 2(b) of ERISA, 29 U.S.C. §1001(b). ERISA itself provides certain important protections "by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect [to ERISA plans], by establishing standards of conduct, responsibility and obligation for fiduciaries of [ERISA] plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." *Id.*

Logically, in enacting the ERISA preemption, Congress would not have wished to preempt certain classes of state laws that themselves might provide important protection to plan participants and beneficiaries. State laws regulating insurance, banking and securities practices were three such areas designated by Congress in the savings clause.

Although Congress, in enacting the savings clause, would logically have sought to gain for ERISA plans the protection of state insurance, banking and securities laws, Congress would not have wanted ERISA plans to bear the burden of these laws by being treated as insurance companies, banks or investment companies. Therefore, it enacted the deemer clause, which provides that an ERISA plan shall not, for purposes of applying state laws which regulate insurance, banking or securities, "be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking. . . ."

In the context of the types of state insurance laws contemplated by Congress in enacting these provisions, the distinction created by the savings clause, on the one hand, and the deemer clause, on the other hand, makes perfect sense. To the extent state insurance laws protect the policyholder, they are saved and may be used by ERISA plans for the

benefit of plan participants and beneficiaries where plans purchase insurance to underwrite benefits. The state, however, may not use these laws to impose obligations on, or restrict the activities of, an ERISA plan by deeming the plan to be an insurer. *Accord Michigan United Food & Commercial Workers Unions v. Baerwaldt,* 572 F Supp. at 952. *See also* Note, *Insurance Regulation—Employee Benefit Plans,* 28 Ark. L. Rev. 515 (1975).

While this structure is logical if the state law is one that regulates the activities or practices of the insurance company in its dealings with policyholders, the logic breaks down where, as here, the state law imposes an obligation on, or restricts the activities of, the policyholder. If such a law is construed to be a law which regulates insurance within the meaning of the savings clause, a strong incentive is created in the policyholder to terminate or avoid the insurance relationship in order to escape the unwanted obligations and restrictions. This is precisely what has happened with respect to state mandated health benefit laws. Because these laws dictate the insurance coverage that ERISA plans must purchase if they purchase any insurance at all, plans that wish to avoid the restrictions placed on their purchasing decisions are inclined to forego insurance and self-fund the health benefits which they elect to provide. Because ERISA plans that self-fund health benefits may not, under the deemer clause, be deemed insurance companies, state mandated health benefit laws are unenforceable against self-funded plans. *General Split Corp. v. Mitchell,* 523 F. Supp. 427 (E.D. Wisc. 1981); *St. Paul Electrical Workers Welfare Fund v. Markman,* 490 F. Supp. 931 (D. Minn. 1980); *Hewlett-Packard Co. v. Barnes,* 425 F. Supp. 1294 (N.D. Cal. 1977), *aff'd per curiam,* 571 F.2d. 502 (9th Cir. 1978).

Congress surely did not intend, in enacting the savings and deemer clauses, to create this arbitrary distinction between insured and uninsured plans, permitting state regulation of plan benefits if they are insured but not if they are uninsured. Yet this is the inescapable, albeit nonsensical, result if state mandated health benefit laws are construed to

be laws which regulate insurance within the meaning of the savings clause.

b.

The conclusion that Congress only intended to save from the ERISA preemption state insurance laws that protect the plan from the practices or activities of insurance companies is consistent with the traditional purposes of state insurance regulation. States, rather than the federal government, have historically protected the policyholder from the potentially injurious practices or activities of insurance companies. Indeed, Congress has recognized this as the exclusive domain of the states. It is logical that Congress, in enacting the ERISA preemption, would have wished to save for the benefit of plan participants and beneficiaries, those state laws which by tradition and common understanding have provided important protections to insurance policyholders. These include regulation of rates, rate-making, unfair and deceptive practices, commissions, investments, and other matters dealing with the cost and reliability of coverage and the fairness of company underwriting practices.[16]

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[16] The United States District Court for the District of Kansas, in holding that a program offered by a third-party payor was not an ERISA plan subject to the ERISA preemption but rather an insurance program subject to state regulation, observed that the purposes of insurance regulation are:

> first, to avoid overreaching by insurers; second, to assure solidity and solvency of insurers; third, to assure that rating classifications and rates are reasonable and fair.

Bell v. Employee Security Benefit Association, 437 F. Supp. 382, 391 (D. Kan. 1977), quoting with approval from Note, *Insurance Regulation—Employee Benefit Plans,* 28 Ark. L. Rev. at 517-18. All of these purposes relate to policyholder protection; none are served by mandated health benefit laws, which instead address concerns of health-care utilization and reimbursement. See also *American Progressive Life & Health Insurance Co. of New York v. Corcoran,* 715 F.2d 784 (2d Cir. 1983), in which the court held that a New York insurance regulation establishing a maximum commission for life insurance salesmen selling to ERISA plans was saved from the ERISA preemption because it was directed at the business conduct of the insurance company. This decision is entirely consistent with the traditional purposes of state insurance regulation to protect the policyholder—in that case the ERISA plan—from insurance company practices.

State laws, like Section 47B, which dictate the coverage that a policyholder must purchase, are not laws within the scope of traditional state insurance regulation. They are not aimed at protecting or regulating the relationship between the insurance company and the policyholder or at maintaining the insurance company's status as a reliable insurer. Rather they are aimed at financing and promoting the utilization of health care services by shifting the payment obligation away from the health care consumer. This is not insurance regulation but health care regulation.

Whatever Massachusetts' interest may be in protecting the interests of health care providers and consumers, it may not elevate this state interest above federal regulation of ERISA plans unless it can establish that this interest falls within one of the narrow exceptions to the ERISA preemption. This it has not done, and given the nature of Section 47B, this it cannot do.

The clear purpose of Section 47B is not to regulate the practices or activities of insurance companies for the protection of policyholders, but rather to use the financial resources of insurance companies, employers, unions and ERISA plans to promote the increased utilization of certain health care services and, not incidentally, to protect the financial interests of certain classes of health care providers.

Because Section 47B dictates the benefits to be provided by ERISA plans, federal law must prevail over state law, regardless of whether these plans are insured or uninsured. The determination of the benefit mix to be provided by such plans must be allowed to proceed under the protection of federal regulation and the collective bargaining process, unfettered by state law.

CONCLUSION

For the reasons stated, the decision of the Supreme Judicial Court for the Commonwealth of Massachusetts should be reversed.

Respectfully submitted,

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